Health Services
LOS ANGELES COUNTY

# DHS Expected Practices

Specialty: Women's Health

Subject: COVID Gyn Onc – Cancers and Preinvasive Lower Genital Tract Neoplasias

Date: April 8, 2020

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**Purpose:**

1. To provide guidance regarding the management of patients with confirmed or suspected gynecologic malignancy and with pre-invasive gynecologic disease in the setting of the COVID-19 global pandemic.
2. To ensure that the access of this highly vulnerable patient population to gynecologic oncology services is not compromised during the COVID-19 pandemic.

**Target Audience:** Gynecologic Oncologists, Obstetrician Gynecologists, Women's Health and Primary Care Providers, and any other providers referring patients with potential gynecologic malignancies.

**Background:** The current understanding of COVID-19 is continually evolving and its impact on the care of gynecologic oncology patients is rapidly changing. Below are considerations based on limited data, which will need to be modified as more information emerges about COVID-19. Gynecologic Oncology patients likely at the highest risk for severe events during this pandemic include patients ≥ 65 years old or patients at any age with significant co-morbidity, patients with ECOG performance status ≥ 2, and those receiving cytotoxic chemotherapy.

This *Expected Practice* was developed by a DHS Specialty-Primary Care Work Group to fulfill the DHS mission to ensure access to high-quality, patient-centered, and cost-effective health care. SPC Work Groups, composed of specialist and primary care provider representatives from across LA County DHS, are guided by 1) real-life practice conditions at our facilities, 2) available clinical evidence, and 3) the principle that we must provide equitable care for the entire population that LA County DHS is responsible for, not just those that appear in front of us. It is recognized that in individual situations a provider's clinical judgment may vary from this *Expected Practice*, but in such cases compelling documentation for the exception should be provided in the medical record.

**Expected Practice:**

## A. When to e-Consult:

Referring providers are encouraged to continue submitting e-Consults to Gynecologic Oncology promptly as they usually would for patients who meet standard referral criteria as outlined on the e-Consult portal. All other patients should be referred to Gynecology as appropriate, including patients with preinvasive lower genital tract neoplasia. E-consults should continue to be reviewed promptly, and patients with high suspicion for or proven gynecologic malignancies should be cared for promptly. E-consults and referrals should not be delayed due to the pandemic.

## B. Preinvasive lower genital tract neoplasias:

1. Low-grade screening tests may have postponement of colposcopy up to 6-12 months.
2. High-grade cervical cancer screening tests should have colposcopic evaluation scheduled within 3-6 months.
3. Biopsy-proven high-grade cervical disease without suspected invasive disease should have treatment procedure scheduled within 3-6 months.
4. Patients with suspected invasive disease should have evaluation within 2-4 weeks.

Colposcopy clinics who postpone and reschedule colposcopies should have a system that ensures patients will receive their colposcopic evaluation and risk-based treatment intervention within the above outlined timeframe.

## C. Gynecologic Malignancies

Patients who should continue to be evaluated and treated:

1. Newly diagnosed cancer and patient with high suspicion for cancer
2. Active cancer in therapy
3. Recurrent cancer patients with symptoms needing urgent treatment or end of life discussion
4. Second opinions may be accomplished with the use of telehealth

Other telehealth considerations:

1. Minimize outpatient office visits as much as safely possible.
2. For cancer surveillance visits, use telehealth or, if very low risk, consider rescheduling for a later date.
3. Conduct low risk postoperative visits (i.e. risk reducing BSO, cervical conization) and discussion of pathology via telehealth.

For patients requiring office visits:

1. Perform symptom screen prior to visit.
2. Physically distance patients in waiting room, ideally 6 feet or more apart.
3. Limit to one or completely restrict visitors to the appointment if possible.
4. Minimize number of staff members who interact with each patient.

Opportunities to postpone surgery and inpatient care:

1. Patient with advanced stage, high grade ovarian cancer should receive neoadjuvant chemotherapy in lieu of primary cytoreduction, and 4-6 cycles of chemotherapy can be considered prior to surgery, depending upon the status of the pandemic.
2. Patients with endometrial complex atypical hyperplasia and FIGO grade 1-2 endometrioid endometrial adenocarcinoma without concern for significant invasive or metastatic disease should be offered progestin therapy (i.e. megestrol acetate or progestin intrauterine device).
3. Primary radiation therapy (+/- chemotherapy sensitization) should be offered for patients with stage IB3 to IVA cervical cancer, and to those with stage IB2 cervical cancer for whom adjuvant radiation therapy is likely.
4. For high grade endometrial cancer, proceed with imaging, and if cancer is advanced stage, offer neoadjuvant chemotherapy.
5. For patients with adnexal masses, surgery should only be offered if there is a suspicion for malignancy, torsion, or hemodynamic compromise (i.e. sepsis related to tubo-ovarian abscess which is not responding to medical management). Gynecologic Oncology should be readily available to review any concerning cases that the Gynecology team is considering managing surgically.

Patients who should still be offered surgery ASAP:

1. High grade endometrial cancer, clinical stage I-II.
2. Suspected early stage ovarian cancer.
3. Patients with suspected or confirmed ovarian low-grade serous carcinoma, early or advanced stage.
4. Cervical cancer with surgery as curative intent.
5. Gestational trophoblastic disease/neoplasia which requires surgical management as standard of care treatment.

Chemotherapy and other cancer directed therapy:

1. Coordinate labs with already existing visits.
2. Consider utilization of chemotherapy regimens that will avoid frequent patient visits (i.e. Q21 day paclitaxel rather than weekly paclitaxel).
3. Offer pre-chemotherapy telemedicine visit for chemotherapy patients who are ECOG 0-1 and have normal lab values for chemotherapy (ANC> 1.5 and no lymphopenia), no major clinically significant co-morbidity (particularly cardiovascular disease and pulmonary disease), and a negative symptom check for acute respiratory illness.

Patients may then proceed directly to infusion without an office visit to minimize the number of contacts.

4. Evaluate enrollment and treatment on clinical trials judiciously based on availability of clinical and research support.
5. Consider more liberal use of granulocyte colony stimulating factor, particularly in patients who are at higher risk of neutropenia.
6. Avoid inpatient administration of chemotherapy, when possible.
7. Offer telemedicine visits for patients who are stable on maintenance therapy.
8. If capacity limited for infusion appointments, priority should be given to patients receiving curative intent treatment, and delays will be permissible for patients receiving treatment for recurrent or incurable cancer.

**References**:


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